

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 28, 2004
9:32 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Mandated report on benefits design and cost sharing in Medicare Advantage Plans

-- Jill Bernstein, Rachel Schmidt

MR. HACKBARTH: Good morning. The first item on our agenda today is the mandated reports on benefits design and cost sharing in Medicare Advantage plans.

DR. BERNSTEIN: Good morning. The MMA mandates that MedPAC submit a report on the extent to which cost-sharing structures in MA plans affect access to covered services or result in enrollee selection based on health status, together with any recommendations for legislation or administration action that the Commission thinks are appropriate. The report is due December 31.

In September we presented background materials and some analyses that suggested that while benefit designs that would contribute to selection or access problems are not systematic or widespread, there is evidence that practices of some plans could lead to high levels of cost sharing for certain services that are less discretionary, for example, chemotherapy.

Today we're going to briefly discuss some findings from additional analyses and present policy options the Commission may want to consider to help beneficiaries make more informed choices and to limit practices that contribute to access problems or biased selection. The first slide addresses an issue raised in discussion in September. That is, do plans offer lower Medicare cost sharing in return for a higher premium?

Looking at benefit data from the plan files that we got from CMS and at the literature, it seems pretty clear that beneficiaries are choosing to enroll in plans that have a prescription drug benefit. You can, for example, that 73 percent of all plans, 34 plus 39 on the chart, the first two rows, offer a drug benefit. And 44 percent of the plans we looked at, 34 plus 10, have no additional premium or they offer a rebate.

For the plans with a drug benefit, the first two rows, we don't see a lot of evidence that additional premiums are related to lower cost sharing for Medicare-covered services. Each cell on the chart shows the percent of each type of plan that requires what we have categorized as higher cost sharing for four types of services. It ends up meaning generally the cost sharing is comparable to fee-for-service with no supplemental coverage.

Although fewer plans that charge a premium have higher cost sharing for inpatient services -- that's the 22 percent up there versus 39 -- cost sharing for the other services in the plans that have a drug benefit are generally about the same.

You can see a difference for plans that don't have a drug benefit, the bottom two rows. For example, only 4 percent of the plans that charge a premium have higher cost sharing for inpatient services compared to 24 percent with no premium. How the introduction of the new drug benefit will change all these

dynamics in 2006 and after is impossible to predict.

Now we're going to turn to the question about whether the benefit structures that have evolved in these MA markets creates selection or access problems.

The question we were asked by Congress was, is there evidence that plan benefit design leads to selection or access problems. The notion behind the question is that plans can use high cost sharing to avoid sicker beneficiaries. But market competition and beneficiary preferences also shape benefit design.

To look for selection, we wanted to look at plan's risk scores to see how healthy their enrollees are and then compare the scores to their cost-sharing requirements. However, we were only able to get information on risk scores for each MA plan contract. This information combines the risk scores for all the individual plans that operate under a single contract, which is usually in a market area.

CMS is working on developing accurate and reliable plan-level risk score information that can be used to review the plan proposals and evaluate possible issues of risk selection, but we don't have those data yet. Instead, we used available information to identify market areas where there is wide variation in enrollee risk scores among participating plans. In those markets we used information from the Medicare personal plan finder on the Medicare.gov web site to look for relationships between contract-level risk scores and plan cost sharing.

Our analyses did not uncover any consistent relationship between contract level risk scores and cost-sharing requirements for Medicare-covered services or other services. This chart shows that on average the same person, in this case a 70 to 74-year-old person in poor health, what they would have to pay out-of-pocket in most of the plans -- we couldn't fit all of them on the chart -- in one of the counties we studied. This is a county where we saw among the widest variations in contract-level risk scores where we thought we'd be most likely to see a relationship between cost sharing and risk.

The out-of-pocket estimates from the Medicare plan finder, which Medicare beneficiaries can download themselves but we made them a little bit easier to read in this chart so you could compare them. We left off the information on premiums from the plan finder. All of these are zero premium plans except for one. The height of the bars generally indicates the plan's cost-sharing structure.

The bars showing average out-of-pocket costs are arranged by contract-level risk scores with the lowest on the left. The chart divides the plans among three groups, those with risk scores under 0.9, those 0.9 to 1.0, and those 1.0 and higher. So you can look across the chart left to right, you see the plans under the contract with enrollees with more health risk as we move across the chart. The bars don't show a consistent pattern of higher cost sharing for contracts with higher risk scores. Some plans under contract with the highest scores, like plan 9A,

have no cost sharing for inpatient care, while others with nearly the same risk score have been relatively higher cost sharing, like plan 7B.

However, until we have plan-level risk scores we can't determine whether cost sharing is associated with significant enrollee risk.

So to illustrate how a person who becomes seriously ill might be affected by cost-sharing provisions we looked even more closely at how things might work in different plans in one market if a person developed a serious health problem. In this example we show what the out-of-pocket cost would be a 70-year-old man for a year following initial diagnosis of stage 3 colon cancer. We provided additional information and context in the background materials which, in summary, confirm that cancer care is expensive.

Based on the information we got from cancer experts in various places, including the National Cancer Institute, we have devised a prototypical set of services for the typical 70-year-old male patient. We included in this chart only the costs related directly to the treatment of cancer care. We also note that new treatment regimens coming online now are substantially higher for chemotherapy than those indicated in what is now the standard treatment that we used in the example.

As we noted in the last meeting and in your background materials, cost sharing for beneficiaries enrolled in MA plans is generally lower than in fee-for-service for most services. The point here, however, is to look at a relatively infrequent but serious possibility. The three plans included on your chart are large plans in another county in a different market are that also has a lot of plans. In any of the plans that we've looked at here, the beneficiary would incur at least a couple thousand dollars in out-of-pocket costs for Medicare-covered services for cancer care. The cost of hospital care for this person would exceed the Medicare fee-for-service hospital deductible in plans one and two, but not in plan three.

But clearly, the big difference is in coinsurance for chemotherapy. 20 percent coinsurance in two of the plans, which is what it would be in fee-for-service without supplemental insurance, is \$5,600. Now this beneficiary knows that with appropriate treatment he will probably survive for a number years, probably many years. Data NCI shared with us indicates that his out-of-pocket costs in subsequent years would be less. But if there is a recurrence they could be substantially higher than those shown here. Whether this prospect affects his decisions about enrolling in a plan or disenrolling from a plan will depend on a lot of factor, but one will be whether he's able to get the information he needs to compare benefits and cost-sharing options.

What kind of cost-sharing information is available? As we already saw, the Medicare personal plan finder on the Medicare web site provides information on estimates out-of-pocket cost for beneficiaries. A person can enter his or her information on age

and health status and get estimates for each plan where they live. The estimates are for four general categories that we showed before, inpatient care, other medical care, outpatient drugs, and dental care, and also premiums. In addition, there are estimates about the average out-of-pocket cost for people with three different high-cost conditions.

The plan finder also has information on how many people left the plans that they are considering joining, and some information on the reasons why they left.

We used this information from the surveys ourselves, as Rachel will tell you in a few minutes, to look a little bit more in detail at the cost sharing, but right now I just want to focus on some of the general issues. This is an example of plan finder information on out-of-pocket cost for beneficiaries with the three high-cost conditions that CMS illustrates on the plan finder. The table shows the same three plans that were used in the cancer example. You can see that for those three plans, out-of-pocket expenses are lower in plan two by a similar magnitude to what we saw in the cancer care example.

However, the average cost shown on this part of the plan finders are for all beneficiaries with these conditions regardless of age or other health care problems. For diabetes, for example, the averages shown here include very high costs for some diabetics with serious comorbid conditions who may experience multiple hospitalizations per year and diabetics whose disease is well controlled. The estimates for high-cost conditions also don't break down the cost by type of service that we saw earlier so we can't tell from this chart whether the costs reflect cost sharing for inpatient care, for other Medicare-covered services, or for uncovered services such as prescriptions drugs.

This is an example of information the beneficiary can find on how many members have left the plans in their areas and why. The beneficiary could, for example, check out the reasons why people left the three plans we've shown in the last two slides, the data on the plan finder from 2002 and their contract-level data.

We see here, however, that in plans one and three, which have the higher out-of-pocket costs, a higher proportion of beneficiaries disenrolled than in the other plan. The reasons they cited were also more likely related to issues to premiums, copayments, or coverage than in plan two, or in the plans in the state or nationally. While the specific reasons that people left the plan is not clear, the beneficiary interested in might get some sense of the issues he might want to dig into before selecting a plan at the next open season.

DR. SCHMIDT: We looked at data from the CAHPS disenrollment reason survey to see whether cost sharing is a main reason beneficiaries cite for leaving MA plans. Ideally, if we had plan-level disenrollment rates, that could then provide a potential signal to CMS of the plans that it might want to take a closer look at. However, a limitation of this approach is the

survey is conducted at the contract level and is still described, often times many distinct plans with different benefit designs are operating under one contract.

Nationwide an average of 10 percent of plan members disenrolled voluntarily in 2002. For historical comparison, we found references in the literature to disenrollment rates of 14 percent in 1994 and 12 percent in 1998, but those might not have been calculated in precisely the same way. In the last two years it's been roughly around 11 percent, 13 percent in 2001 and about 10 percent in 2002.

CMS groups disenrollment reasons into the five categories that are shown on this slide. You can see that the largest proportion of disenrollees fall into the category called issues with premiums, copayments or coverage. When we looked at the individual responses that fall within this category, most are related to concerns about cost and best value. The category also includes concerns that beneficiaries had when their plans began charging or raised premiums. Since we are particularly focusing on whether cost sharing has led beneficiaries to disenroll, this category probably overstates the rates of disenrollment that we are particularly interested in.

In addition, many of the responses are ambiguous to the survey. They could be referring to dissatisfaction with cost sharing, with premiums, with both, or some other features of the plans. Very few of the responses are unambiguously associated with cost sharing.

We also took a look at the distribution of plans and enrollees by their rates of voluntary disenrollments that are associated with cost and value concerns. This slide shows you how many plans fall into the groupings of disenrollment rates that are on the bottom of the slide. These are just for the largest category from the previous slide, which was issues with premiums, copayments and coverage.

So 107 of the MA contracts had zero to 5 percent of their enrollees leave for those reasons. Another 31 contracts had 5 percent to 10 percent leave, and so on. Combined, about 90 percent of the plans had rates of disenrollment associated with cost concerns of 10 percent or less. Likewise, most enrollment is in plans with very low disenrollment Roman rates.

The bottom line of this slide is that the vast majority of plans and enrollees have relatively low rates of voluntary disenrollment associated with cost and value concerns. I don't mean to dismiss the situations of beneficiaries who disenroll. They may have experienced some very real problems with the benefit design or cost sharing in their plans. But we're trying to get a sense of how widespread a problem discontent with cost sharing is, and these data seem to suggest that it is not widespread. Remember that this chart includes people who left because they were unhappy with premium increases and other reasons in addition to how a plan designed their cost sharing.

This does not directly measure whether access to care of beneficiaries is affected by benefit design but it does give you

a sense that most plans do not have large numbers of people leaving because of cost.

Here's what I think we've learned from our research so far. On the left-hand side of the slide you can see some summary points. As we started out with and we told you, these are similar to what we found from the meeting of our expert panel back in March, it seems as though the benefit designs to contribute to selection or access problems do not appear to be very widespread. However, we did see some evidence that are plans that do have some high cost sharing for some types of services that one might consider non-discretionary in nature.

Another issue that we had highlighted is that we think helping beneficiaries to understand their options, the financial and personal implications of them, is quite a challenge.

So we would like you to turn to some categories of policy options that are described further in your materials. The study's mandate says that our report is to include recommendations for legislative and administrative action, if you as a commission consider it appropriate to do so. Your mailings materials included some discussion about the categories of policy options that appear on the right-hand side of the slide. I'll go into them in a bit more detail.

One thing that we found in doing this research is that the quality of information submitted to CMS on benefit designs, particularly the plan benefit package data, are sometimes not accurate or coded consistently. That's not surprising because MA benefits are complex and it's hard to provide that detail to CMS. But the same data that we looked at are used to develop the personal plan finder and the out-of-pocket estimates in that to help consumers choose among their options, and unless a plan catches its own mistake those data may not get fixed.

Another issue is that while the personal plan finder provides more useful information than has been available in the past, it is not as tailored as what other plans and programs offer. It has estimates of average out-of-pocket cost for a beneficiary who is in the same age and health status as the consumer who is interested, or in some cases has the same type of chronic condition. But it still averages people who have less use of services together with people who have more. Other approaches, such as some web-based tools offered by private plans, or even the Consumer Checkbook guide to FEHBP provide particular scenarios of use of services along with an indication of how likely the scenarios are to occur, and that might give some more tailored information.

CMS considered that approach when it developed its current method for showing out-of-pocket cost in the personal plan finder, but at the time it considered that too burdensome to beneficiaries to be entering a lot of information about their use of services. The agency is now reviewing options for more sophisticated softwares, wizards and those sorts of things, for consumers who would like to get more information.

CMS is considering a range of options but it has not yet

decided what sort of estimates of out-of-pocket it will be able to provide in the plan finder for 2006. It has some concerns about being to estimate out-of-pocket spending for the new Medicare drug benefit that's going to begin in that particular year. Yet information about cost sharing it seems would be particularly important for beneficiaries in that year.

While we are mailing materials focused on the plan finder, we thought we should remind you that there are other channels to provide consumers with information about MA plans, and those include the 1-800 Medicare line and the state health insurance assistance programs. Those approaches involve more one-on-one discussions or conversations with beneficiaries which may be a more effective means of communication for some people. So we think providing counselors with training and information about benefits design and potential out-of-pocket costs is another avenue for helping beneficiaries make informed choices, but it would also require greater resources.

At our September meeting we described the process that CMS uses to review and approve plan proposals. We also described the fact that under the MMA CMS gained authority to negotiate with plans over their bids in a manner similar to that of OPM for administering FEHBP. So it seems that the agency has some authority to steer plans away from benefit designs that encourage enrollment by healthier beneficiaries or encourage disenrollment of sicker ones. CMS anticipates that its workload will increase with this new negotiation authority but it does not yet know the magnitude of that increase but it's not clear how many plans they'll actually need to be negotiating with.

There's also uncertainty about what level of staff resources CMS will have for these reviews and negotiations. The Center for Beneficiary Choices has some dedicated personnel. The Office of the Actuary will also participate, and I think there are some plans perhaps to pull in some contractors to help during the months in reviewing plan bids.

It's hard to make precise comparisons but we found that the number of staff who are involved in CMS's oversight functions may be smaller than what OPM has for negotiating with plans under FEHBP. This raises the question of whether CMS has sufficient resources and as much flexibility as it might need to manage those resources well.

FEHBP has a larger number of covered lives than does the Medicare Advantage program, but CMS has more plans to review and its negotiation and approval function or arguably more complex than OPM's. The reason it's more complex is that for most FEHBP plans OPM compares changes in premiums to what those same plans charged similarly-sized groups in the commercial market. By comparison, CMS will need to review MA plans more closely and negotiate over benefit designs that are more likely to be different from those available in the commercial market.

There may be ways to provide CMS with more flexibility to better manage the resources that it has or build in some surge capacity for those months in which it will be reviewing bids and

negotiating. It may also be a challenge to coordinate staff within CMS because several parts of CMS play a role in this function.

Finally, we have several mutually exclusive approaches that the Commission might want to consider to help prevent benefit designs that are discriminatory among potential enrollees. It's probably important to keep in mind something that we pointed out in September and that is there's a lot of uncertainty surrounding the MA program at this particular point in time because there are so many changes underway, including the phase in of new risk adjusters, moving to a system of bidding, the introduction of Part D, and regional PPOs as some example.

But let's forge ahead and discuss these options. One approach would be for CMS to develop a few standard benefits packages that plans would have to use. The main advantage of this approach is that beneficiaries would find it easier to compare plans and assess their value than they do today. This option could also ensure that plans do not have relatively high cost sharing for services that are less discretionary in nature.

The disadvantages of using standard benefits are that they may not suit the market conditions and preferences of all parts of the country, and they could make it difficult for plans to develop new products that better suit beneficiary needs. If this approach were used, CMS would need to modify standard packages periodically to keep up with market innovations.

Another approach would be for CMS to propose the use of certain benefit structures. If plans use those benefit designs, CMS would not subject the plan to as much oversight as it would get otherwise. This is similar in approach to CMS's current policy of recommending that plans use an out-of-pocket cap. The advantage of this approach is that it could lead to less confusion for beneficiaries without directly requiring a standard benefit. It would also potentially reduce CMS's workload because the agency could focus on the plans that are using a different benefit structure. But plans would only adopt the proposed benefit design if CMS's oversight process placed significant barriers on using a different design.

In a third approach, CMS would identify certain types of services that would be subject to standardization. This approach could range from having modular benefit designs for all parts of service to just picking out a few categories, such as some that seem less discretionary in nature. Keeping some of the current flexibility that plans have would allow them to adjust cost sharing in areas where there's arguably overuse of services yet would protect beneficiaries in situations where they have less discretion.

A final option would let plans keep most of the flexibility they have today except that they would have to adopt a catastrophic cap. CMS currently suggests an out-of-pocket cap but it is not required. After 2006, regional PPOs are required to include a cap, but the MMA does not specify at what level. This approach may not simplify things much for beneficiaries but

it would provide enrollees in some plans with greater protection than they have today.

At this point we would like to turn to you all and get your feedback on this.

MR. HACKBARTH: This report is due December 31 and given that after this meeting we will increasingly have to spend time at our meetings on the update issues that we have to address in the January report I'd really like to conclude this discussion at this meeting. You'll notice that there are not any draft recommendations. Staff, I think correctly felt, that we didn't quite crystallize the discussion enough at the last meeting to bring draft recommendations to this meeting. What I'd like to get out of this discussion right now is some clear direction for staff that could be overnight formulated into draft recommendations that would come back tomorrow that we could vote on. So that's my objective.

So what I'd like to do is, maybe a little bit more than usual, try to have a quite structured discussion here today. I think one way to do that, if you would put up page 11 from the overheads, we've got the three categories of policy options, help beneficiaries make more informed choices, bolster CMS's negotiating role with plans, and prevent discriminatory benefit designs. What I'd like to do is just go through those in order and get your thoughts so we can't formulate recommendations. So let's begin with helping beneficiaries make informed choices.

DR. REISCHAUER: Is anybody against that?

MR. MULLER: Thank you for the excellent report. I read this to say that the question being asked of us in terms of how access is affected by the cost sharing is that neither the plans nor the beneficiaries use it in any kind of linear or authoritative way to drive choice. Given the other analysis that we've done, it strikes me that the fruit is still in terms of understanding the total cost per beneficiary and that the real gain to be made in the program is as plans select "right beneficiary" that has lower cost. Therefore, to me that strikes me that having CMS understand more fully what the costs are per beneficiary and try to keep plans from selecting the lower-cost patient is the right way to be thinking about this.

Also in my own experience, and I think the evidence here is, getting people to understand the cost of medical care is very complex. On a running basis, cost sharing, figuring out every month -- we all have our stories of helping Mom or Dad figure out their EOB every Sunday morning, but figuring out your premium once a year is about as much as people can figure out in terms of making choices. Trying to do it on any kind of concurrent basis may be beyond the capacity of any of us to understand. So that leads me to think about how one sets premium levels and how one looks at total cost rather than cost sharing. That's how I read this.

Is that a fair evaluation of what you have come up with?

DR. SCHMIDT: I suppose so. In terms of ascribing a motive to plans, I don't think that there is evidence to do that well.

I'm taking this from your initial comment on how you were interpreting the results of what we wrote up. It seems to me that selection, there's a component that's a two-way street. Beneficiaries try to look for what's in their best interest in a plan, and plans may in fact need to, for example, raise revenue in some cases by charging higher copays, or they could be engaging strategically. We just don't know if many circumstances. I think the evidence that we saw was not compelling to put it squarely in the lap of plans, I would say.

DR. MILLER: I might have heard something different over here. Ralph, tell me if this is what you were saying. Was the paper directing better information for the beneficiary to be pitched at the premium and total cost level as opposed to helping beneficiaries understanding the cost-sharing structure?

If that's what you're asking, I would say I felt like the paper wasn't headed in that direction. That the paper was saying there were ways to present potential out-of-pocket impact for the beneficiary in the way that gave them a clearer idea of what they might incur. That rather than a big, lumpy average you could say, average cost sharing for somebody with a hospitalization and without and then tell the beneficiary the probability of a hospitalization. So break it down a little bit for them. But I may still misunderstand your question.

MR. MULLER: I obviously wasn't very clear so let me try again. I read this to say that neither the beneficiary nor the plans seem to use cost sharing very effectively to drive choice. That the beneficiaries don't understand it as well as they might, and the plans don't use it as effectively as they might. So therefore there must be some other vehicle, some other lever they use.

I would surmise that, based on incentives, that -- certainly employers do this in the non-Medicare market, they try to figure out the total cost of care, and the evidence we see of people dropping dependents and so forth from coverage is a function of the cost of coverage and so forth. So I would assume inside the Medicare plan as well the total cost of covering a beneficiary is what plans would look at and that's more of a driver of their behavior, the total cost, in terms of enrolling people or not.

Then one obviously can use premium information as well. But I read this to say in cost sharing, despite hypotheses that we might have had, does not seem to have as much effect either on beneficiary behavior or how plans behave.

MR. HACKBARTH: Certainly cost sharing as opposed to premiums is more difficult for beneficiaries to get a grip on, which is the challenge. It's more difficult for them to comprehend the implications of the cost-sharing structure for them.

MR. MULLER: It's more difficult for plans to get a grip on.

MR. HACKBARTH: I think they've got more information and way more skill.

MR. MULLER: But they don't seem to use it consistently to drive behavior.

MR. HACKBARTH: There are others around the table more expert in that than I am. But just to focus on the beneficiary point for a second. The challenge that I think we have is that beneficiaries tend to focus on premiums because that's easier to compare and understand, and comparing premiums that are missing very important differences potentially in the benefit structure, the cost-sharing structure, that could have dramatic implications for them depending on their circumstances. So the challenge is can we find ways to help beneficiaries analyze that complex choice?

At the last session, Arnie for one and perhaps others as well, said that Medicare right now is -- these are my words, not Arnie's -- lagging behind the state-of-the-art in decision-support tools, and there are software tools out there that help people make these comparisons and choices. Is that a fair statement, a fair summary? So that would be one type of approach.

A second big category is more resources, more telephone-based help through SHIP or some other mechanism so people can be talked through these decisions. I think those are the two major approaches that are being discussed. So if we could get some feedback on what can we recommend, what should we recommend, those two categories. Are people in favor of more resources, or is there another major option?

MR. BERTKO: Just a quick comment again to thank the staff for a very good report on the issue. I'd strongly support this first recommendation of more communication and note that in addition to perhaps coding errors, the current format that CMS records plan decisions on is fairly rigid, in which case there is sometimes difficulty inserting in the actual benefit decisions, which probably limit how people look at this. So more resources by CMS, perhaps whether it's better decision-support tools or more flexibility in terms of recording the actual cost sharing could be helpful and I think would reduce errors and help explain better.

MR. HACKBARTH: Could you just explain for me the more flexibility in recording?

MR. BERTKO: Sure. I'm not sure if this is an example but on the Part A first-day deductible, fee-for-service is \$876, and as you insert there, is it a copay, is it a copay per day, is it a copay limited by a certain amount? As you begin inserting more complicated versions of that, because plans in pre-MMA days were managing to the amount of revenue available, those ways to structure the Part A cost sharing became more complex. It's my understanding from at least a year ago that it was difficult for us as a plan to report in to CMS in the prescribed format the variations of that. So a little bit more flexibility, saying free-form text, would be useful.

Then CMS has the second problem of getting that into plan finder, which I think is a pretty good tool but could serve also to be improved in the future.

MS. BURKE: Let me focus specifically on the question you

asked in terms of the information for the beneficiary. On page 26 of the document -- and my thanks for the work the staff did on this -- there is a suggestion in the last paragraph that CMS currently plans to remove projections of out-of-pocket payments from the plan finder in 2006. That's a little further ahead than where we are today but let me use it as a jumping off point.

I think as a general matter, the more information that we give to people the better if it's in a form that in fact can be useful. I think one of the messages that I would suggest that we as a commission want to send is that it is incumbent upon us to make as much information available as possible, and suggestions that they simply drop whole categories out rather than try to deal with the issue, which is how do you accommodate the fact that there will be a drug benefit, I think is the wrong direction. So I think we ought to make it very clear early often that our goal here is in fact to provide information.

To the point that Ralph was making and also Glenn has made, and that is the issue as to whether or not people's decisions are more clearly driven by premium as compared to out-of-pocket, because it's a much more clearly articulated number. You can look and you can look behind the plans. It's obviously an inadequate measure from a beneficiary standpoint because the impact of the cost sharing can have such an extraordinary impact on them as compared to premium. If as we saw in the plans that you compared, it can have a substantial difference on an individual if in fact there's cost sharing on drugs, or cost sharing on any number of other things.

So I would err on the side of giving more information in both forms, both in the sense that you have it available to you in a plan finder, that we adjust the plan finder as necessary to make it more readily available to an individual to look at it. You made some suggestions in terms of doing a variety of options so that it's not simply the average person, that there are different ways to construct the plan finder. I would encourage us to say that we think that is a useful tool that ought to be improved upon, that there will be people who will find it more useful than others. There are always going to be people who are only going to look at one thing, or who are incapable of managing that kind of a system.

But I think it ought not discourage us from having it available. Whether it's the child of a parent utilizing it or the parent themselves, I think we ought to have it available, it ought to be modified to the extent it can be to make it a more realistic test of what expectations would be: if I'm healthy, if I am chronically ill, what my expectations of use would be.

So I guess my concern is that we ought to discourage them from pulling stuff out because they're not sure how to deal with it, that we ought to certainly articulate a strong view that more tools ought to be available to the beneficiary in making decisions, and I think it ought to be not only the premium but in fact the extent to which we can improve the information on cost sharing so it is a more useful tool for folks to manage, I think

is going to be critical.

I think anything short of that would be a real disadvantage for beneficiaries. It isn't perfect as it is. It isn't easy to use, but at the moment it's the best thing we have and it can be improved upon. So I would send that message very strongly in any report that we would have.

DR. SCHMIDT: We'd like to clarify one thing that was in the mailing materials. That is, after the mailing materials went out we had other conversations with CMS and it's not so definitive that they plan to drop the out-of-pocket estimates in 2006. They're still considering their options.

MS. BURKE: Let's make that clear.

DR. MILSTEIN: First I want to reinforce my prior suggestion that informed beneficiary choice of plan I think could be very much improved if it took advantage of current best available tools of predictive modeling. We have made a lot of progress, actually primarily in other applications of predictive modeling, than improving a beneficiary's ability to know how much enrolling in a particular plan is going to cost them personally in the subsequent year. But those advanced predictive modeling tools are not currently part of the Medicare program, the Medicare plan finder.

If you then take the next step and say, what would it take for Medicare beneficiaries when choosing plans to be able to access or get the benefit of current advanced predictive modeling tools? It would require Medicare beneficiaries to be able to authorize the pushing of their personal prior 12 or 24 months worth of claims history into the predictive modeler. Now that in turn would require CMS, for its fee-for-service database, to mobilize it and have it available such that if a beneficiary said, I'd like to know for me personally, given my personal health history, what my likely expenses would be in Plan A versus Plan B. There's a fair amount that Medicare would have to do with the traditional Medicare database to get a ready for use in a customized and fresh feed into best available predictive modelers, but not undoable.

MR. HACKBARTH: Do employers do that currently or does that have a direct feed into the software so that --

DR. MILSTEIN: More advanced. Not all by any means.

If you think about it, once somebody was in a plan, if they wanted to model what the implications would be of switching plans, that same easy availability of personal claims history would also be something that would be their entitlement when they're in a Medicare Advantage plan. They'd be able to take their current history and then run it through the modeler.

DR. REISCHAUER: Can I just ask a question on that? That is, to the extent these plans are offering benefits that are in addition to the Medicare required benefits and that's a very attractive aspect of these plans, might not this particular methodology that you're suggesting provide them with a biased set of information? Because it will say, of your Medicare-eligible costs you'd do a whole lot better, but the person is really

interested in their vision and dental costs. So you'd be steering them maybe in the wrong direction.

DR. MILSTEIN: There's no question that your accuracy in predictive modeling would be higher if you were modeling future health care use based on a plan that had identical benefits as the plan you had been in. But that said, you could still get a lot of predictive power, even if you were coming out of a plan that had a different and more lean set of benefits than the one you were thinking about. So a predictive modeler would still work, just it's accuracy would go down by a certain number of percentage points. But it would still be a much more accurate predictor than what we currently do which is, how old are you, what's your gender, and please answer the following short list of questions about what you can remember about your health status. Your ability to then anticipate what a plan is going to cost you out-of-pocket is going to be far reduced relative to what a really good predictive modeler, interacting with your claims data, even for a plan that had a different benefits schedule, would be able to accomplish today.

The second point I want to make is, if we think about such a world in which Medicare beneficiaries would have something better than their sons and daughters to try to figure out which is the best deal for them, as it were, you would also want to be able to think about a modeler that would distinguish between what a plan would cost you if you did and did not accept the plan's preferred option.

So for example, if it's a Medicare Advantage PPO plan and I go out of network, I'd like to know -- you'd have to have some ability for people to know how much of it would cost them if they stayed within their plan's recommended formulary and recommended network versus if they strayed, because that would in most Medicare Advantage plans have significant, different implications.

So those are my two comments. The first is the one I wanted to emphasize, but these are things that are easily within current technology and I think that we'll look back on the current period in which people were asked you -- we gave people predictions based on age, gender and then filtered it through their sons and daughters and say, how did we ever accept that, because I think we can do much better.

MS. BURKE: That would be a great thing to get to when we could get ticket to it. It occurs to me, Social Security currently does an analysis and we each get a letter -- maybe it's age-based and only some of us get the letter -- each year that calculates what it is that our retirement benefits would be. It's actually quite a useful sort of document.

Similarly, you could imagine, to the point that you would have available or an outside contractor could have access to the Medicare files, a similar letter that would go out that would say, last year you used X in terms of your benefits. That might allow people to use the current model even if we begin to have access to the more advanced predictive modeling. But to the

extent that Medicare could do that in is similar form, there's history there in Social Security. Whether there's a similar kind of opportunity with Medicare as at least a first step it might well be a useful tool for someone to say, this is what happened last year. You used the following services.

To the extent that we could have access to that might at least move us in that direction, which I think over the long term would make a lot of sense.

MR. HACKBARTH: Given the nature of this report, this commission, obviously we don't have the wherewithal to review specific tools and say, this is the one you ought to use. So we're simply pointing in a direction and realizing, I think we need to reflect in the attached language that we know that there some issues to get from where we are today to where Medicare ought to be in the future.

So the message that we want to convey is there is a different way out there, it's being used in the real world. This is very important, and we urge that you move in that direction with some dispatch. I don't think we can go too much further than that.

DR. MILSTEIN: I just want to reinforce, most people who are in a plan may well not realize, based on last year's change in health status, there's a lot better value plan for them in their community available now. So I really want to reinforce Sheila's notion of it being something that is actively made available to beneficiaries when, based on a fresh review of their health status there is a plan that represents a better value in their community.

DR. SCANLON: Following up on the last couple of comments, I think that we do need to emphasize what the short-term recommendations we want CMS to consider versus the longer term. I have no issue that it may be ideal to get to a point where beneficiaries have actual information about their experience and that they can put into some system or some model and get some recommendations.

Nancy-Ann can probably tell you better than I, but Medicare is not there today in terms of getting that information on any kind of a timely basis, and the kinds of system changes that would be required to do this are really quite dramatic. Social Security is a piece of cake in comparison to Medicare. We have had about a decade of trying to modernize Medicare's information systems and we're still very far from being anywhere close to what you might think of is reflective of today's technology, because all over the world things are happening amazingly with respect to IT. But Medicare is still not there.

So I think we need to emphasize for CMS the short-term changes are also critically important in terms of what kinds of things to highlight in plan finder, what kinds of things to highlight in other materials. I think some of the suggestions in the report are very good.

Distributional issues are big. Diabetes, the number there surprised me in terms of, we've got a lot of people with a

diagnosis of diabetes who are not going to occur necessarily that much expenditure. But we've got in extreme who are going to incur a lot, and people need to know about that.

The other thing I would say, and this is in part in reaction to Ralph's comments. I don't think we know a lot about cost sharing either by plans or beneficiaries, and that's appropriate because our question was, are plans using cost sharing to skew their populations? I think we basically found that they're not for the most part. There may be some exceptions. So that question is answered.

But in the process of doing this we discovered the difficult that consumers will have in terms of trying to pick a plan, and that's an area where we need to try to make some progress. So I think moving in that direction is a positive step and goes beyond the narrowness of the original question that we got from the Congress.

DR. REISCHAUER: Following on what Bill said, it strikes me that the bottom line of this is that our examination found that there was no evidence or no conclusive evidence of egregious benefit design to skew the risk pool that a plan has. This might be because CMS does have the authority to look over their shoulders, and maybe you want to strengthen that authority a little bit. It could be because any commercial plan would be foolish to get itself in a position where CMS announced or the public announced this plan has maliciously designed its benefits to screw the sick, and they wouldn't be able to market for years in that area.

Given that situation, we should look at these options and dip into the least intrusive it strikes me. More information for beneficiaries, better, more modern tools for making these estimates, fine. More resources for CMS if it feels that it needs them or we think it should.

If plans and CMS thought it would be beneficial, the existence of safe harbors I think makes sense, just to ease the burden, unless plans say we really don't care about that and CMS says it really wouldn't reduce our workload very much. But going much beyond that really at this point isn't necessary, given what this analysis shows.

While I'm sympathetic to Arnie's world, I do see that it's somewhat in the future and I think that there really are limits to the extent to which Medicare beneficiaries are going to rely on these kinds of information and tools. All the evidence we have about the way Americans make decisions with respect to consumer items and even things like health suggest that they aren't extremely analytical. Even when they have all the tools in the world and all the analytical information they could have they turn to their neighbor and say, what do you have and do you like it?

When you think about this kind of decision, lots of people who are making these decisions are basically healthy. If they are halfway through treatment for an episode of cancer they usually aren't looking around for alternatives. If they are in a

plan and they have developed cancer and are halfway through the episode, they often are more concerned about their perceived quality of care that their receiving and their relationships than they are with the cost sharing.

So even if we provide lot of water here, it's not clear the horses are going to drink, I think. That's not an excuse for not doing it so that 30, 40 years from now when a new generation of beneficiaries who are analytically oriented and all have engineering degrees comes of age, this will be useful.

DR. MILSTEIN: I certainly agree with a lot of the empirical findings you cite today that given the challenges of being an informed consumer that most consumers opt not to do it. But I think my enthusiasm for the version that both Sheila and Nancy alluded to is precisely because it would not require any energy or analytic effort on the behalf of the beneficiary. That is, what I'm envisioning here is something analogous to a blue light special at Kmart where essentially on a periodic basis, based on a beneficiary's personal health history, if there is a plan available to them that would represent a lot better bargain, the blue light goes on and they are alerted to it. They can turn it down or not turn it down. But you don't have to be an engineer in order to respond to a blue light special.

DR. REISCHAUER: But you talked about better value and better value seemed to be cost-sharing premiums. But there are a whole lot of other dimensions to health care that people are concerned about; their relationship with individual providers, the distance to those providers, the range of providers and all that, and you can't bring goes in.

Now that doesn't mean you shouldn't provide this. But the blue light special is usually a product everybody knows all the dimensions of and what people are comparing it on is relative cost.

DR. MILSTEIN: I think that Bob's point is absolutely right that there are certainly a lot more dimensions to which plan I pick than price only. But that said, I think we can do a lot better than we're currently doing to help beneficiaries anticipate what the out-of-pocket cost to them would be of a given plan option which is the scope of what I was addressing.

The other thing is this comment about we know that Americans default to what the person over the back fence tells them they should do with respect to health care. I think that is a default and I think it remains to be seen whether or not if we made it easy and transparent and trustworthy whether or not a lot more Americans wouldn't feel comfortable with alternatives to what their neighbor tells them over the back fence.

DR. WAKEFIELD: Just a comment and a question, staying with Bob's horse and water analogy. My comment is an interest in ensuring that all the horses that choose to drink have the option to get to the water and they know where the water is. So following up on that my point is, it seems to me it might be worth mentioning somewhere in this report a comment about any extra effort that individuals view as necessary to ensure that

vulnerable populations within the larger beneficiary pool have access to information.

So for example, I think having web-based information is a terrific thing and knowing that plan finder is there, it sounds like that's an excellent resource. Some limitations, but overall an excellent resource. But I'm concerned about those minority groups, rural populations that at least today and for the near-term foreseeable future may not have access to information that way. True, there's a 1-800 out here. How do we ensure that as many people as possible know that that exists, for example?

So just a nod to recognize that perhaps some particular attention needs to be paid so that everybody who wants to avail themselves of information is aware that. Maybe there could be that sort of a comment made in the report, because I'm not sure that this information is going to diffuse out in as smooth and organized a fashion as we might hope it would.

The question I've got for you is, in terms of avenues for providing information, this function carried out by SHIPs at the state level, are those functions funded purely through Medicare or is there any responsibility for the state to pick up some of this pushing information out the door to senior citizen centers and so on?

DR. BERNSTEIN: Most states, either through their offices of aging or insurance provide additional support to the SHIPs. The last survey I saw there was huge variation in the extent to which they received help from either the states or from other organizations that they partnered with.

DR. WAKEFIELD: So this is not a fully Medicare-funded activity then when people are trying to move information out to beneficiaries?

DR. BERNSTEIN: No.

DR. WAKEFIELD: That's a concern from my perspective in terms of equal access to information for those states that have the resources to put on the table to support this information on a federal program versus those states that either choose not to or don't have the resources.

DR. BERNSTEIN: They definitely need help from other organizations. In some states you can go to a SHIP and you can sit down with a counselor for hours who will pour over this stuff with you or help you over the phone. Other states have much less support to the SHIPs.

DR. WAKEFIELD: It seems to me highlighting that as a potential problem in terms of access to information ought to be part of this report as well.

MR. HACKBARTH: We are at the end of the allotted time so I really want to try to, as quickly as possible, bring this to a conclusion and provide some direction for the staff on the issues of CMS negotiating authority and preventing discriminatory benefit designs, the other two components here.

I agree with a Bob's summary that on the immediate question we were offered, is there a lot of this activity of discriminatory benefit designs, the answer is no, based on what

we've been able to find.

Having said that, it was not zero. There were some instances, so I think what I'd like to see us say along those lines is that if it were to increase, it would be a problem. But because it isn't a problem right now we don't want to, as Bob recommended, go into the excessively regulatory restrictive options. They are simply not merited based on the facts we have in front of us.

I am personally concerned that if it were to proliferate, if we would have more plans with low cost sharing for everybody except for cancer patients, that that is detrimental to the Medicare program, to Medicare beneficiaries, to the other private plans in the marketplace. I think maybe a way to strike the appropriate balance by assuring that CMS has in fact that negotiating authority and isn't limited to simply pleading with plans or threatening to put their names in the newspaper but can say, this is an unacceptable discriminatory design.

Now I have a question about that. When we were discussing this issue, briefing congressional staff on it, at least some of them thought that the existing MMA language which grants CMS authority on discriminatory design for drug benefits actually was broader and covered local MA plans.

DR. SCHMIDT: It does. The language basically says that CMS has authority similar to that of OPM for administering FEHBP, and OPM's authority is quite broad. It includes setting minimum benefit standards.

If you look, however, in the proposed rules that CMS has written about the MA plan, they're interpreting this, similar to, to mean that the Medicare benefit is a bit different. That there is a defined A, B fee-for-service benefit and they don't think that they have authority to negotiate about that.

However, when we move into a world in which there is bidding, plans are bidding on the A, B benefit, there's some rebate money that may result and CMS thinks it does have authority to negotiate on the level of benefits provided with those rebate dollars.

DR. MILLER: The point is, although the legislative language implies it's very broad, FEHBP-like, the regulation could be read to mean that they're going to negotiate on a much more narrow platform, which is the rebate that the plan is giving. Glenn, to your point, if you want to be clear that the Commission thinks that the authority should be broad, we could make a statement that the interpretation might track more closely to what we think the law says. Is that fair?

DR. SCHMIDT: I think that's a fair comment.

MR. HACKBARTH: Let me advance to two other specific ideas that have been discussed. So we think CMS ought to have the authority. Now are there additional steps that ought to be taken? One idea that has been suggested multiple times is the idea of a safe harbor. If you don't want to be subject to CMS's discretion about this you can go into a safe harbor, which is clearly defined as non-discriminatory, and be okay.

I'd like to ask our plan people their reaction to that concept. John and Jay and everybody else who wants to leap in.

MR. BERTKO: Going to page 14, I think that the bottom three, the safe harbor, possibly the standardizations, and then the last one, which is the catastrophic cap which I view as a subset of the safe harbor, would all be workable types of things.

MR. HACKBARTH: The catastrophic cap was going to be the next one that I go to, whether we ought to recommend that there be a catastrophic cap.

MR. BERTKO: The first one I would make two points on. I think I made one a while back and the staff here have acknowledged this, if you have standard plans, they tend to become obsolete after a while. I would also suggest that in the context of January 1, 2006 there's a lot of uncertainty on the new programs, and rather than introduce additional uncertainty, using two, three, or four of these options would allow permission but not require it.

So for example, the safe harbor in my interpretation says, if you're in the safe harbor you go a quick pass through. If you decide to do your own you have then the possible burden of defending that, and to me that's quite acceptable.

MR. HACKBARTH: That's helpful. I was taking number one off as maybe a bit of an over-reaction to what we have seen to this point. I was focused on two, and four on this list as opposed to designing the modular benefits, which I think is a lot of work to do to set up that system. So I was really --

DR. REISCHAUER: The catastrophic cap could be an alternative element of the safe harbor. Choose this benefit design or you have a catastrophic cap.

MR. HACKBARTH: Exactly. It could be a choice for the plan. Jay, did you have any thoughts?

DR. CROSSON: Similar thoughts. I agree with Bob's analysis here that the narrow question that the Commission was asked, is there evidence that plans are using benefit design to drive selection? The answer is there does not appear to be much evidence.

But in the analysis, as well as the initial intuitive look at this, there's been a concern that while that may be true, in a small number of plans there may be, advertently or inadvertently, an effect on a small set of vulnerable individual beneficiaries who happen to find out that they have a disease for which the burden then in a particular plan would be beyond their ability to manage.

So I think I also agree with Bob that whatever we recommend as a fix, given the answer to the narrow question being negative, often to be narrowly designed. It also ought to be effective and we ought to have the sense that it probably will work.

Now as I looked at these, I think I agree that the first one seems to be as over-reaction. I also agree with John that probably any one of the other three would work. I was actually most attracted by number three, not so much that I think we ought to go hog wild and design modular benefits well beyond the

problem identified, but I wondered about whether a narrower approach, one really focused in on a smaller subset of non-discretionary services, might in fact be an approach that is more tailored to the problem identified. I don't know whether the right term then is modular benefits. It might be something more, a targeted beneficiary protection standardized benefit.

MR. HACKBARTH: I think you and I see this in a quite similar way. I am quite concerned about disproportionate cost sharing on people with serious illnesses where the services are basically non-discretionary. I have little tolerance for that. I think that's for one purpose and for one purpose only, which is to skim good risk or eliminate bad risk. But we don't want to over-react. We're not seeing wholesale evidence of that.

I think the modular benefits concept is an interesting one, but I am reluctant to recommend something that I don't really fully comprehend how it would work. Maybe what we could do is have some text language that says, there are some particular areas of concern. Based on our last discussion, I think there was general concern about high cost sharing or disproportionate cost sharing on non-discretionary service. We could include reference to that in the text and say that maybe one thing that CMS could do in the exercise of its discretion is focus in on those sensitive areas and define the safe harbor idea for those particularly sensitive areas. Would that meet your --

DR. CROSSON: Yes, I think that's essentially what I was saying.

MR. HACKBARTH: We are 10 minutes over right now. I don't want to cut off any important comments but please keep them brief.

DR. SCANLON: I'd like to suggest that we think about this catastrophic cap, because in part it's only an extension to the local plans since we already have a catastrophic cap in law for the regional plans. I think that's probably one of the most important things you can do. It's the thing that's missing in traditional Medicare. You talk about a person who has non-discretionary services, in traditional Medicare they're also incredibly vulnerable.

MR. HACKBARTH: So you're arguing in favor of the catastrophic cap?

DR. SCANLON: I'm arguing in favor of the cap.

MR. HACKBARTH: Just to be clear, what I would envision is that we would recommend two and four. So we would recommend that a catastrophic cap be established as there is proposed to be, or legislated to be for the regional PPOs.

DR. SCANLON: I think this is a recommendation to the Congress as opposed to CMS. You do it within your negotiation authority but you do it --

MR. HACKBARTH: Yes, that is a legislative recommendation.

DR. REISCHAUER: Are you suggesting that this would be a requirement or an option for a safe harbor?

DR. SCANLON: I think it should be a requirement. The Congress has already said that for regional plans there needs to

be catastrophic cap, and that the same kind of cap could be applied in local plans. I don't understand why it wouldn't be, especially given the evidence that we have found, that there are plans for which there can be extremely high expenses for certain individuals. It's not a lot of plans, as we have shown, and it would be protecting a relatively small number, but extremely affected individuals.

MS. BURKE: Nancy-Ann and I were just chatting about this. There's an interesting question here. The Congress has historically talked about catastrophic caps in the broader context. This is a relatively narrow context. Query how it will be perceived. We're talking about it solely in the context of the plans. Bill is right, they've just done it in the context of the regional plans. We would now be saying it in the context of the Medicare Advantage plans. Query the historical discussion around fee-for-service and the whole context of a catastrophic cap. It has some interesting political overtones that we may want to reflect on. It's an interesting set of issues.

DR. REISCHAUER: I just have two short comments related to what Jay was talking about. One is that as we fully phase in risk adjustment, some of the incentive that existed when we were collecting this data should be even smaller than it is now.

The second comment would be with respect to option three there. I have the feeling that when we're looking at cost sharing we're talking about the front door of the barn, but we're leaving the back door open, and does it make any sense to close the front door? Cost sharing is certainly one way to affect the attractiveness of different risk groups to your plan, but so is the nature of your provider group, the geographic location of the facilities. Plans have all sorts of other tools they could use if they were perniciously interested in affecting this besides cost sharing, which is in a sense, the most overt and easily detectable one. So we shouldn't put a lot of effort into closing the front door of the barn if we're going to leave the back door open.

MS. DePARLE: Just a small point. We do need to clarify the authority because I agree with Mark, the way I've understood it is that they were thinking of their authority to negotiate almost as an actuarial exercise. It probably needs to be clarified that we think it should be broader.

But in addition to that, I think we need to make the point that CMS also needs to have the capacity, the oversight capacity here to do what it needs to do. While OPM is being held up as a standard for this, I at least recall when I was the budget person at the Office of Management and Budget responsible for OPM, hearing from them multiple times and actually having the impression myself that they really didn't have adequate resources to do what was being advertised on their behalf, and what they're doing is much different than what we're expecting CMS to do for the plans. So I'd like us to make the point about capacity too.

MR. HACKBARTH: Anybody else?

DR. WOLTER: Just real briefly, just to put a minority

opinion on the table.

I think the issue of simplification is an important issue. I think the complexity of the choices is very high. From the provider standpoint, the intersection between the plan benefit design and the copay, et cetera, and the billing done by providers is a huge source of dissatisfaction to patients and comes through very strongly in patient satisfaction surveys and other things. I worry about that piece of this.

There's also a fair amount of cost on the provider side because often it's the provider who becomes the source of information to the patient about benefit designs. We have found this, for example, in the drug discount card where there's huge dissatisfaction with the complexity of the choices and we become the resource, so there's a fair amount of cost and time spent there. So I wouldn't discount the first choice up there entirely. I think this is an issue for seniors and it's an issue for providers.

MR. HACKBARTH: Anybody else? Arnie, last word.

DR. MILSTEIN: The option for catastrophic cap, that can be interpreted in a variety of ways. Some ways of interpreting it could work very much to the disadvantage of efficiency improvement in the Medicare program and in the American health care industry overall. We don't have time to discuss it, but maybe in our recommendations we could take that into account.

I want to refer to my earlier comment, are we talking about, for example, if Jay's plan or John's plan offers a PPO Medicare Advantage option, would we want the catastrophic cap to apply to out-of-network care, non-formulary drugs?

MR. HACKBARTH: We need to move on for right now. I anticipate that we'll have some draft recommendations for tomorrow that we can consider at that point.

Thank you very much. Good work.

Next up is imaging services and strategies used by private plans.

CONTINUED FROM OCTOBER 28th

MR. HACKBARTH: Okay, thank you. Well done.

We are going to now turn to the recommendations on Medicare Advantage and complete that before we move on to specialty hospitals.

Since we've been through the entire set, I think we can dispense with any reading. We'll just pause for a second, let people read what's on the screen, have brief discussion, as brief as possible please, and then proceed to a vote.

DR. REISCHAUER: I'm sort of wondering why we have the year 2006 in there. I mean, I know that's when they were planning or maybe would drop it. But until we have better measures we should continue it. So we just drop the 2006.

MR. HACKBARTH: Fine. Right.

Okay, all opposed to recommendation one? Abstentions? All in favor?

Let's put up two.
All opposed to number two? Abstentions? In favor?
DR. SCHMIDT: I think there's a word missing in the very
last tick. I think it was limitations on disproportionately high
cost-sharing.
MR. HACKBARTH: Yes.
Okay, all opposed? Abstentions? In favor?
Okay. Thank you.
Okay, next on the agenda is specialty hospitals.